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**Body Blow:
Mature Minors and the Supreme Court of Canada's Decision in
*A.C. v. Manitoba (Director of Child & Family Services)***

Shawn H.E. Harmon*

Abstract: Autonomy, appropriately defined as the preservation, if not the creation, of space—physical and intellectual—to exercise one's own judgment, is the mantra of the modern era, and the foundation of many legal rights and doctrines, particularly in the medical law context. Though it is persistently extended, particularly in the West, we recognize that it is not the only value that moves us, and this fact causes tensions and poses challenges, as amply demonstrated by the 26 June 2009 decision of the Supreme Court of Canada in *A.C. v. Manitoba (Director of Child & Family Services)*, a case in which a mature minor was forced to receive medical treatment to which neither she nor her parents were willing to consent. This paper considers the Court's decision in this case with a view to exploring in detail its treatment of autonomy and that value's derivative rights, as well as its engagement with other values, critiquing the case and the trend that it (and other Jehovah's Witness cases) signals.

INTRODUCTION

Autonomy, variously described as “liberty”, “freedom”, and “the protection of personal integrity”,¹ it is the mantra of the modern era, and the foundation of many legal instruments, doctrines, and rights, both international and domestic. However, though we are absolutely wedded to it—particularly in the West where it has a strong legal voice²—and though it is persistently extended, most of us recognize that it is not, nor should it be, the only value that moves us; it cannot be absolute. And this recognition causes tensions and poses challenges, as amply demonstrated by the 26 June 2009 decision of the Supreme Court of Canada (“SCC”) in *A.C. v. Manitoba (Director of Child & Family Services)* (“AC”).³ This case comment considers, first, the primacy of autonomy, and then the equivocations that we have erected around its vindication, doing so within the context of the AC case. In short, it considers autonomy against the backdrop of a recent and important medical law decision of the SCC. It then offers some preliminary observations about the position and value of the AC case in the autonomy and medical law universes, referencing the *Canadian Charter of Rights and Freedoms* (“Charter”) in the process.⁴

BACKGROUND

AC is about a minor who challenged a court order to treat her medically in the absence of her consent, indeed contrary to her clearly stated desire. The facts, very briefly, are as follows:

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¹ Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (Oxford: OUP, 1994) at 121-127, discusses the notion of autonomy in the medical context.

² Again in the medical context, see e.g. R. Gillon, “Ethics Needs Principles – Four Can Encompass the Rest and Respect for Autonomy should be ‘First Among Equals’” (2003) 29 *Journal of Medical Ethics* 307.

³ *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, 309 D.L.R. (4th) 581 [AC].

⁴ Part I of the *Constitution Act, 1982*, being schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

- The appellant, A.C., a minor aged 14 years and 10 months, suffered from lower gastrointestinal bleeding when admitted to the hospital.⁵ As a Jehovah's Witness, she refused a blood transfusion and informed her physicians of the same, additionally indicating that she had an Advance Directive instructing that she not receive transfusions. Her parents supported her decision.
- The following day, her treating physician requested an assessment to determine A.C.'s capacity to refuse treatment, which included the capacity to understand the consequences of doing so, including the risk of death. The report, completed by three psychiatrists, stated that A.C. was alert, cooperative, bright, well spoken, and occasionally teary, and had no psychiatric illness, concluding that A.C. understood why a transfusion may be recommended as well as the consequences of refusal.
- A few days later, A.C. experienced more internal bleeding. A transfusion was recommended. She refused it. She was apprehended as "a child in need of protection" under section 17 of the Manitoba *Child and Family Services Act* ("CFSA").⁶ Under subsection 25(8) of that act, a court order was sought authorizing blood transfusions as deemed necessary by the physician; the medical evidence demonstrated that if A.C. did not receive blood, she faced "significant risk" associated with oxygen deprivation.⁷
- Without having undertaken an assessment of her maturity, the Provincial Court assumed that A.C. had capacity, but granted the treatment order, stating that a child under sixteen years is squarely within the court's authority to order medical treatment in her best interests, and that hers were served by the proposed intervention. Treatment was subsequently administered and A.C. recovered.
- A.C. and her parents appealed the decision to the Manitoba Court of Appeal, which dismissed the appeal. They then appealed to the SCC, arguing that the CFSA violated the *Charter* by infringing section 2(a) (freedom of religion), section 7 (security of the person), and section 15(1) (freedom from discrimination based on age) because it denied her (and others under sixteen) the right to demonstrate capacity and have their treatment wishes respected.

The case before the SCC turned primarily on the interpretation and application of section 25 of the CFSA, which authorizes child protection authorities to impose treatment on minors in the absence of consent.

Ultimately, a medical examination can be authorized by the agency where the consent of a parent or guardian would otherwise be required. Under paragraph 25(1)(c), medical treatment can be authorized if:

- (i) the treatment is recommended by a duly qualified medical practitioner;
- (ii) the consent of a parent or guardian would otherwise be required; and
- (iii) no parent or guardian is available to consent to the treatment.

Further sections of the CFSA clarify the following:

- Where a child is sixteen or over, neither medical examination nor treatment can be authorized without the consent of the child. When a child sixteen or over refuses consent, or when the

⁵ The Manitoba *Age of Majority Act*, C.C.S.M. c. A7, s. 1(1) defines a "child" as anyone under the age of "majority" (i.e., 18).

⁶ S.M. 1985-86, c.8, C.C.S.M. c. C80.

⁷ *Supra* note 3 at para. 11, Abella J.

parents of a child under sixteen refuse consent, the authorities may apply to a court for an order authorizing the treatment.⁸

- The court may, upon completion of a hearing, authorize any medical treatment that it considers to be in the best interests of the child.⁹
- The court shall not make an order with respect to a child sixteen or older without the child's consent unless it finds that the child is unable (a) to understand the information that is relevant to making a decision to consent or not consent to the medical ... treatment; or (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent ...¹⁰

THE PRIMACY OF AUTONOMY

As a socio-ethical value, autonomy, grounded in the dignity and worth of the human person, might be defined as involving the preservation, if not the specific creation, of space—physical, emotional, and intellectual—to exercise one's own judgment and to vindicate one's own will with respect to matters relating to oneself.¹¹ As shall be discussed, in Canada, the concept of autonomy is implicated in both constitutional law and medical common law, which, together, protect freedoms relating to thought, decision, and action, all of which are constituent elements of autonomy writ large.

With respect to Canadian constitutional law as it is implicated by the *AC* case, sections 2(a) and 7 of the *Charter* state:

2. Everyone has the following fundamental freedoms: (a) freedom of conscience and religion;

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Generally, subsection 2(a) erects a zone of protection from state interference around (1) an individual's personal beliefs about the foundation of "truth" relating to creation, existence, and human nature, or a philosophy of life; (2) the institutions in which individuals participate relating to the same; and (3) the practices individuals undertake as a result of membership in those institutions.¹² The right will be infringed where (1) the claimant sincerely or profoundly holds a belief or practice that has a nexus with religion, and (2) the state action interferes with the claimant's ability to act in accordance with that belief in a manner that is more than trivial or insubstantial.¹³ As explicitly noted in *R. v. Big M Drug Mart Ltd.*, the right rests on the values of autonomy and dignity, the objective being to shelter from state interference of a non-trivial nature profoundly personal beliefs that govern one's perception of oneself, humankind, nature and, sometimes, a higher or different order of being, and that therefore govern one's conduct and practices.¹⁴

⁸ *Ibid.* ss. 25(2)(3).

⁹ *Ibid.* s. 25(8).

¹⁰ *Ibid.* s. 25(9).

¹¹ See Shawn Harmon, "Regulation of Human Genomics and Genetic Biotechnology: Risks, Values and Analytical Criteria" (2005) InnoGen WP-40, online: Genomics Network <<http://www.genomicsnetwork.ac.uk/media/Innogen%20Working%20Paper%2040.pdf>>.

¹² See *R. v. Jones*, [1986] 2 S.C.R. 284, 31 D.L.R. (4th) 569 [Jones]; *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, 35 D.L.R. (4th) 1 [Edwards Books]; and *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, 310 D.L.R. (4th) 193, 9 Alta. L.R. (5th) 1 [Hutterian], for more on freedom of religion. *Hutterian*, citing *Metropolitan Church of Bessarabia and Others v. Moldova*, No. 45701/99, ECHR 2001-XII (ECHR), notes that freedom of religion has both individual and group elements.

¹³ *Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551, 241 D.L.R. (4th) 1.

¹⁴ [1985] 1 S.C.R. 295 at paras. 94-99, 123, 18 D.L.R. (4th) 321 [Big M Drug Mart].

Section 7 protects two autonomy-implicating rights: “liberty” and “security of the person”.¹⁵ In *R. v. Big M Drug Mart Ltd.*¹⁶ and *R. v. Oakes*,¹⁷ Chief Justice Dickson articulated the concepts that inform the constitutional right of liberty as follows:

- respect for individual conscience and judgment, which lies at the heart of our democratic political tradition;
- respect for the ability of each individual to make free and informed decisions, which is a prerequisite for the legitimacy, acceptability, and efficacy of our system of self-government;
- respect for human dignity, commitment to social justice and equality, accommodation of plurality and cultural/group identity, and faith in social and political institutions, all of which enhance participation in society.

It has been held that liberty is infringed when the state interferes with the following: (1) individual abilities to develop and realize their potential, plan their life to suit their character, make choices, be non-conformist, idiosyncratic, or eccentric;¹⁸ (2) individual rights to make fundamental choices such as where one resides;¹⁹ (3) parental rights to raise children in accordance with their conscientious beliefs;²⁰ (4) parental decision-making with respect to children’s medical care;²¹ and (5) access to medical treatment without undue delay.²²

An individual’s right to security of the person has both physical and psychological components; it is infringed when the state actually violates physical integrity through punishment or infliction of suffering, threatens to violate physical integrity, or causes psychological trauma by treating individuals as a means to an end rather than as a valued end in themselves, stigmatizing the individual, imposing stress and anxiety through the imposition of uncertainty, disruption, publicity, expense, and so on.²³ In short, section 7 extends to individuals’ security over their physical and mental integrity and the right to maintain and control the same.²⁴ As such, in *R. v. Morgentaler*,²⁵ it was held that state interference with bodily integrity and state-imposed psychological stress due to the imposition of the criminal law—both stemming from an attempt by the state to control a woman’s capacity to reproduce—constitute a breach of the security of the person.

Given the above, the section 7 rights of liberty and security of the person implicate in a very deep and direct way the value of autonomy in that they are directed at providing the individual with

¹⁵ See *Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177 at paras. 41-49, 17 D.L.R. (4th) 422 [*Singh*] (Wilson J. clarified that s. 7 contained three separate interests which had to be protected); *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, 24 D.L.R. (4th) 536 (reiterated the interests set out by Wilson J. in *Singh*); see also *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342 [*Rodriguez*] (Sopinka J. stated that the right to life, grounded on the respect for life value, stood against the others and none could prevail a priori over another). In line with Sopinka J., I would argue that the first interest, “life”, is not particularly autonomy-implicating, although the exercise of autonomy certainly depends on the existence of life.

¹⁶ *Supra* note 14 at paras. 94-95.

¹⁷ [1986] 1 S.C.R. 103, at paras. 29, 61.

¹⁸ *Jones*, *supra* note 12 at para. 76.

¹⁹ *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 at paras. 58-72, 152 D.L.R. (4th) 577.

²⁰ *Jones*, *supra* note 12 at paras. 79-81.

²¹ *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 at 362-74, 122 D.L.R. (4th) 1.

²² *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791 at paras. 28, 43, 109-125, 254 D.L.R. (4th) 577 [*Chaoulli*].

²³ See *Singh*, *supra* note 15; *Chaoulli*, *ibid.*; *R. v. Therens*, [1985] 1 S.C.R. 613, 18 D.L.R. (4th) 655; *Mills v. The Queen*, [1986] 1 S.C.R. 863, 29 D.L.R. (4th) 161; *R. v. Whyte*, [1988] 2 S.C.R. 3, 51 D.L.R. (4th) 481; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, 177 D.L.R. (4th) 124; and *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307, 190 D.L.R. (4th) 513 [*Blencoe*].

²⁴ See *R. v. Videoflicks Ltd.* (1984), 48 O.R. (2d) 395 (C.A.), 14 D.L.R. (4th) 10.

²⁵ [1988] 1 S.C.R. 30, at 56, 173, 44 D.L.R. (4th) 385 [*Morgentaler*].

the physical space and safety and psychological/emotional space and safety to make judgments as to what is best for herself and to exercise her will in conformity therewith. In *Big M Drug Mart*, Chief Justice Dickson held that liberty constitutes allowing individuals room to exercise personal autonomy to live their lives and to make decisions that are of fundamental personal importance.²⁶ Similarly, in *Morgentaler*, Justice Wilson stated that liberty grants the individual a degree of autonomy in making decisions of fundamental personal importance and pursuing one's own conception of a full and rewarding life.²⁷

As indicated above, autonomy is also implicated in the medical common law. Support for the value can be found in practices and doctrines relating to consent to treatment, patients' rights to information, and health data protection, all of which are critically important in the modern clinical and medical research settings.²⁸ With respect to consent, which is considered one of the most significant vehicles for realizing autonomy and the self-determination that it supports,²⁹ the following propositions can be distilled from the common law,³⁰ and were endorsed by Justice Abella in the majority judgment of *AC*:

- There is a rebuttable presumption that adults are competent, and the burden of disproving competence rests on the person challenging it.³¹
- Adults are entitled to sufficient information to make a decision that is informed, and to direct the course of their own medical treatment through the giving or refusing of informed consent.³²
- The power to direct one's own medical treatment includes the right to refuse life-saving treatment.³³
- While physicians cannot normally proceed in the absence of consent, an exception exists where emergency circumstances prevail and the person is not in a position to give or refuse consent, the assumption being that consent is implied or that the physician is entitled to proceed on the basis of necessity.³⁴

These rights were traditionally restricted where minors were concerned (and in certain limited public health situations), but those restrictions on autonomy have been eroded.³⁵ Thus, whereas most minors were long considered a vulnerable class in need of (paternalistic) adult guidance and state

²⁶ *Supra* note 14 at paras. 94-95.

²⁷ *Supra* note 25; see also *Blencoe*, *supra* note 23.

²⁸ See *Morgentaler*, *ibid.* (Dickson C.J.C. noted that, at common law, medical procedures carried out on a person without that person's consent constitutes an assault, a position grounded in physical integrity); see also Simon Verdun-Jones & David Weisstub, "Consent to Human Experimentation in Québec: The Application of the Civil Law Principle of Personal Inviolability to Protect Special Populations" (1995) 18 *Int'l J. L. & Psychiatry* 163. The medical common law has evolved to include more protections, many informed by autonomy as an emerging value. Many of the common law protections (e.g. consent to treatment) originate in the concept of physical inviolability, which is aimed at protecting the physical integrity of the patient.

²⁹ Verdun-Jones & Weisstub, *ibid.*; Bruce J. Winick, "On Autonomy: Legal and Psychological Perspectives" (1992) 37 *Vill. L. Rev.* 1705.

³⁰ See *Rodriguez*, *supra* note 15; *Morgentaler*, *supra* note 28; *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1; *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.), 67 D.L.R. (4th) 321 [*Malette*]; *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), 82 D.L.R. (4th) 298 [*Fleming*].

³¹ *Supra* note 3 at para. 40.

³² *Ibid.*

³³ *Ibid.* at paras. 44-45.

³⁴ *Ibid.* at para. 42.

³⁵ See *ibid.* at para. 46, Abella J.

protection,³⁶ the common law has, relatively recently, recognized decisional capacity in minors, extending to them autonomy-based consent as well as refusal powers, even in respect of illnesses and conditions with dire consequences.³⁷ Hence, it is now accepted that parental authority declines in accordance with the minor's evolution into adulthood, and, provided the minor is capable of understanding the proposed treatment and of expressing her wishes, those wishes must be considered (though may not be determinative). Again, the majority judgment supported these propositions.³⁸

Emphasizing the great societal importance attached to individual integrity and liberty, and noting that this importance is reflected in our legal system, Justice Abella stated:

The legal environment for adults making medical treatment decisions is important because it demonstrates the tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity.

She later quoted favourably from *Fleming v. Reid*,³⁹ wherein it was held that every person's body is inviolate, an idea deeply rooted and tied to consent, and she further exposed our appetite for autonomy by suggesting that a minor's best interests will, as she gets older and more mature, collapse into her desire and right to exercise autonomy.⁴⁰ In short, there comes a time when it is in the child's best interests to exercise autonomy, whatever consequences the exercise of that autonomy might result in; her best interests are *the exercise* of autonomy.

Chief Justice McLachlin, writing for herself and Justice Rothstein, was also autonomy-supportive, but no opinion demonstrated a stronger claim that autonomy occupied the pinnacle of legal value than that of Justice Binnie, who, in dissent, after describing forced medical treatment as one of the most egregious violations of a person's integrity, stated:

[It] is ... fundamental that every competent individual is entitled to autonomy to choose or not to choose medical treatment except as that autonomy may be limited or prescribed within the framework of the Constitution. The rights under s. 2(a) of the *Charter* (religious freedom) and s. 7 (liberty and security of the person) are given to *everyone*, including individuals under 16 years old.⁴¹

He concluded that the SCC has "long preached the values of individual autonomy," and he characterized this case as a call to live up to the autonomy promise contained in sections 2(a) and 7.⁴² Justice Binnie went on to hold that the state's interest in controlling the medical treatment of minors ceases where a minor, though under the age of sixteen, demonstrates maturity and thus has no need for any overriding state control; the legitimate basis of state intervention has, by reason of the finding of maturity, disappeared, and the minor is entitled to live or die by her decision.⁴³ He noted that, in the present case, three psychiatrists and the judge at first instance accepted that A.C. had capacity.⁴⁴ Subsection 25(8) prevented her from making the decision on her own and therefore contravened sections 2(a) and 7; it created an irrebuttable presumption of incapacity that was not justified by section 1 of the *Charter*.

³⁶ Exceptions here are emancipated minors and mature minors, the latter being a relatively recent conceptualization.

³⁷ This extension began in the U.K. with *Gillick v. West Norfolk & Wisbech Area Health Authority*, [1985] 3 All E.R. 402 (H.L.), [1985] 3 W.L.R. 830, but quickly found a foothold in Canada in *J.S.C. v. Wren* (1986), 76 A.R. 115 (C.A.), 35 D.L.R. (4th) 419 and *Van Mol (Guardian Ad Litem of) v. Ashmore* (1999), 168 D.L.R. (4th) 637 (B.C.C.A.), 168 D.L.R. (4th) 637, among other cases.

³⁸ *AC*, *supra* note 3 at paras. 46-63, Abella J.

³⁹ *Supra* note 30.

⁴⁰ *AC*, *supra* note 3 at paras. 84-98.

⁴¹ *Ibid.* at para. 192.

⁴² *Ibid.* at para. 219.

⁴³ *Ibid.* at paras. 221-224.

⁴⁴ *Ibid.* at para. 225.

The above demonstrates that autonomy is deeply embedded in Canadian society, is legally mandated and constitutionally protected, and has been extended in the health context beyond historical categories to persons we (still) consider incompetent to do many things. The *CFSA* empowers competent minors ages sixteen to eighteen to exercise the same autonomy rights as an adult; minors under sixteen, who have demonstrated their capacity, can express their wishes and have those wishes considered. Ultimately, while Justice Binnie's vision did not carry the day, the *CFSA* dramatically lowers the age at which children can have a hand in decision-making.

TENSIONS AND EQUIVOCATIONS AROUND AUTONOMY

However, the *AC* case is not about the unfettered triumph of autonomy. As the case demonstrates, we find ways to circumvent the exercise of autonomy when we consider it just or expedient. Thus, minors, even mature minors, can have their wishes overridden where the court, in exercising its *parens patriae* jurisdiction or, as here, interpreting statutory provisions, is of the opinion that their best interests are served by another course. Justice Abella, for the majority, took some care in explaining that the requisite maturity comes gradually and unevenly, and is dependent on personal characteristics and context.⁴⁵ She explained:

There is considerable support for the notion that while many adolescents may have the technical ability to make complex decisions, this does not always mean that they will have the necessary maturity and independence of judgment to make truly autonomous choices.⁴⁶

Moreover, maturity is terribly difficult to measure, and where we are not satisfied that it has been demonstrated, having reference to a number of factors, the court should determine the appropriate course with input from the minor. On that issue, Justice Abella concluded:

With our evolving understanding has come the recognition that the quality of decision-making about a child is enhanced by input from that child. The extent to which that input affects the best interests assessment is as variable as the child's circumstances, but one thing that can be said with certainty is that the input becomes increasingly determinative as the child matures. This is true ... when deciding whether to accede to a child's wishes in medical treatment situations.⁴⁷

The consequence of the *CFSA*, as interpreted by Justice Abella, is that if we cannot trust that a minor will exercise true autonomy, we will not permit her to make the decision, and, additionally, we will weigh her input accordingly. In such a case, her best interests must be protected.⁴⁸ The assessment of her best interests is structured in the present case by subsection 2(1) of the *CFSA*:

2(1) The best interests of the child shall be the paramount consideration ... and in determining best interests ... all other relevant matters shall be considered, including the following:

- (a) the child's opportunity to have a parent-child relationship as a wanted and needed member within a family structure;
- (b) the mental, emotional, physical and educational needs of the child and the appropriate care or treatment, or both, to meet such needs;

⁴⁵ *Ibid.* at paras. 71-79 (here, Abella J. cited a variety of scholarly material).

⁴⁶ *Ibid.* at para. 71.

⁴⁷ *Ibid.* at para. 92.

⁴⁸ Ultimately, as a minor, her objective best interests must be protected, and they are heavily coloured by the respect for life value. Once that minor becomes an adult, her best interests, as far as the state is concerned, are largely synonymous with the exercise of her own judgment, whatever consequence that might have for her life, health, or treatment.

- (c) the child's mental, emotional and physical stage of development;
- (d) the child's sense of continuity and need for permanency with the least possible disruption;
- (e) the merits and the risks of any plan proposed by the agency that would be caring for the child compared with the merits and the risks of the child returning to or remaining within the family;
- (f) the views and preferences of the child where they can reasonably be ascertained;
- (g) the effect upon the child of any delay in the final disposition of the proceedings; and
- (h) the child's cultural, linguistic, racial and religious heritage.

An integral element of this assessment is the preferences of the minor. In determining the weight that should be given to those preferences, the minor's maturity must be rigorously assessed.⁴⁹ In paragraph 96 of the majority judgement, Justice Abella clarifies that the following factors require consideration:

- "What is the nature, purpose, utility/benefits and risks of the recommended treatment?"
- "Does the minor demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision, and to appreciate the potential consequences?"
- "Is there reason to believe that the minor's views are stable, and a true reflection of her core values and beliefs?"
- "What is the potential impact of the adolescent's [i.e., minor's] lifestyle, family relationships and broader social affiliations on her ability to exercise independent judgment?"
- "Are there any existing emotional or psychiatric vulnerabilities?"
- "Does the adolescent's [i.e., minor's] illness or condition impact on her decision-making ability?"
- "Is there any relevant information from adults who know the adolescent, like teachers or doctors?"

This represents a structured attempt to realize another important value, not so much respect for life, but solidarity with others; to demonstrate our conviction, alluded to in the *CFSA*'s preamble, that society has a duty to protect minors; to help them flourish to the extent permitted by the operation of other important values and existing socio-economic structures. The consequence for the minor is that she need only be afforded a degree of autonomy, imprecisely commensurate with her maturity, and society is to be afforded the right to paternalistically protect her life and health and vouchsafe her ability to flourish, all to a diminishing extent as she ages.

Such was the conclusion of Justice Abella and Chief Justice McLachlin, both of whom found the *CFSA* constitutionally sound (or saved). Drawing on the common law, Justice Abella stated that the multifactorial best interests approach embodied in subsection 25(8) erects a sliding scale of scrutiny whereby the minor's views become increasingly determinative with greater maturity; the more serious the nature of the decision and the more severe its potential health impact, the greater the degree of scrutiny required.⁵⁰ Minors under sixteen have the right to demonstrate maturity, and courts making decisions on their behalf must give weight to their opinion commensurate with that maturity. In assessing maturity, the court must take into account the above factors. So construed, the *CFSA* strikes a constitutional balance between an individual's fundamental right to autonomous decision-making and the law's attempts to protect the vulnerable from harm, and it does not violate

⁴⁹ See *AC*, *supra* note 3 at paras. 94-96, Abella J.

⁵⁰ *Ibid.* at paras. 108-116.

sections 2(a), 7, or 15 of the *Charter*; it is neither arbitrary, discriminatory, nor contrary to religious freedom.

In a minority opinion concurring in result, Chief Justice McLachlin rejected the common law as irrelevant,⁵¹ and stated that bodily integrity (protected by section 7's security of the person interest) is not absolute and does not trump all other interests; limits on autonomy-grounded section 7 rights that advance a genuine state interest are acceptable where shown to be based on rational (non-arbitrary) grounds.⁵² She opined that (1) the statutory scheme successfully balances autonomy with society's interest in ensuring that minors receive necessary care, and (2) using age sixteen to impose the burden of proving maturity is a legitimate response to concerns about coercion and influence (i.e., age is a reasonable proxy for independence and ability to understand and appreciate consequences of the decision and alternatives).⁵³ As such, section 7 was not violated. With respect to section 15, she noted that the discrimination-founding ground (i.e., age) must create disadvantage by perpetuating prejudice or stereotype.⁵⁴ Children are recognized as a highly vulnerable group.⁵⁵ Hence, the use of age in the present setting (i.e., the requirement that the judge take into account the treatment preferences of those under sixteen where maturity is demonstrated) is ameliorative, and thus not contrary to section 15.⁵⁶ Finally, while the scheme does violate subsection 2(a), it is justifiable under section 1 of the *Charter* because the objective of ensuring the health, safety, and life of vulnerable minors is pressing and substantial, and the means chosen—giving discretion to the court to order treatment after a consideration of all relevant circumstances—is a proportionate limit.⁵⁷

Such was the decision. A.C. received her treatment, her post hoc appeal was dismissed, the statutory scheme was found to be constitutional and the authorities were concomitantly exonerated of any wrongdoing, and A.C. lived to fight another day. The question remains: What is the value of this case, generally, with respect to its implications for autonomy as a value, and with respect to the rights of liberty, security of the person, and freedom of religion, all of which are at least partially grounded on autonomy (and their support of prior consent to medical treatment and the duty to obtain it)?

VALUING THE CASE: AUTONOMY, MATURITY & HONESTY

The Case Generally

From a general standpoint, this case is important insofar as the majority judgment summarizes and clarifies the common law of consent to medical treatment for adults and mature minors. Additionally, and equally pragmatically, it reasonably and clearly outlines the proper process, under this particular statutory scheme, for assessing maturity and approaching decisions with respect to minors of different ages. Having said that, an obvious criticism of the case stems from the bewildering conclusion of Chief Justice McLachlin that no reviewable error had been committed by the application judge.⁵⁸ While the passing of the medical emergency (and indeed of A.C.'s status as an under-sixteen minor) makes this point less significant, the fact remains that Justice Kaufman utterly failed to anticipate (and thus comply with) the demands of the *CFSA* as enunciated by the majority. He never subjected the psychiatric report to a searching judicial review, refused to allow A.C. to present evidence at the conference call hearing of her capacity, and erroneously concluded that such evidence from her would be irrelevant because she was under sixteen.⁵⁹

⁵¹ *Ibid.* at paras. 123-126.

⁵² *Ibid.* at para. 137.

⁵³ *Ibid.* at paras. 134-149 (McLachlin C.J.C. limited her analysis to s. 7 and its internal limitations, and did not make reference to s. 1 of the *Charter*).

⁵⁴ *Ibid.* at para. 150.

⁵⁵ See *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, 2004 SCC 4, [2004] 1 S.C.R. 76, 234 D.L.R. (4th) 257.

⁵⁶ See *AC*, *supra* note 3 at para. 152, McLachlin C.J.C.

⁵⁷ *Ibid.* at paras. 153-156, McLachlin C.J.C.

⁵⁸ *Ibid.* at para. 159; see also paras. 118-121 (Abella J. found the issue of the validity of the treatment order to be moot).

⁵⁹ *Ibid.* at paras. 10-12, 118-120, 159 & 173.

The Case and the Autonomy Value

With respect to the autonomy value more specifically, the case is ambivalent. Although autonomy continues to dominate in Western medical practices, and its importance to that setting (and others) is explicitly accepted, the case explicitly recognizes the tensions between our demands for autonomy, on the one hand, and our lingering (if often un-vindicated) sense of responsibility toward others, including minors, on the other hand.⁶⁰ This is both important and valuable. Unfortunately, the decision did not actively or intellectually engage with these tensions in an entirely satisfactory manner, and is therefore perhaps more significant for what it fails to do. Most significantly, again from a value-perspective, it fails to:

- offer authoritative definitions of autonomy, solidarity and respect for life as moving social and ethical values;
- explore the interaction of these values with the implicated constitutional rights and therefore the practical demands of these values; and
- undertake a deep interrogation of the appropriate balance between these values in the context of a “best interests of the child” assessment.

While some of these undertakings were not strictly necessary for the disposition of the case, their explicit consideration would certainly have contributed to a richer decision. Moreover, as an undeniably important institution for social and policy development within our constitutional setting, the SCC might be expected to engage with these higher level values, particularly in the medical law setting which is so imbued with concepts of social, ethical, and constitutional significance.

The Case and Autonomy-Derivative Rights

With respect to the case’s engagement with *rights* derivative of autonomy, particularly the fundamental right of freedom of religion and the more mechanistic right of consent in the medical context, the value of the case can be similarly questioned.

With respect to the second derivative right—the exercise of consent in the medical context—there are two points worth mentioning briefly. First, there is the majority and concurring judgments’ differential treatment of minors over sixteen and minors under sixteen. One might argue that this differential treatment is curious in the absence of any evidence of a compelling state interest in subjecting the medical treatment of those under sixteen to judicial control irrespective of their capacity to make such decisions themselves. Searching criticism has already been levelled against them for this unsupported differentiation which need not be repeated here.⁶¹

Second, there is the blunt manner in which the state interjected itself between the minor patient and the exercise of her autonomy through the evidence-light procedure of having her declared “a child in need of protection” under the *CFSA*. Despite A.C.’s apparent competence, and her parents’ support of her non-consent, the state is statutorily powered to (and did) intervene, setting in motion a process that altogether removed A.C.’s decisional capacity and vested it in the courts. While rhetorical affinity for autonomy may endure, and may even, to some extent, be reiterated in the statutory scheme, the process itself amply demonstrates the tensions noted above.

With respect to the former and more fundamental right of religious freedom, the case offered little guidance—and less hope—around the vindication of this subsection 2(a) *Charter* right in this particular setting. It is well known that the rejection of blood transfusions by Jehovah’s Witnesses is fundamental to their religious convictions. They believe that blood represents life, and they interpret the Bible to mean that respect for the gift of life requires them to abstain from accepting blood—

⁶⁰ The two concurring judgments pointed out that minors under 16 are often not fully formed beings to whom we should abdicate all decision-making powers.

⁶¹ See *AC*, *supra* note 3 at paras. 206-237, Binnie J., dissenting.

through food, drink or transfusion—to sustain life, even in times of emergency.⁶² Devout Jehovah's Witnesses understand a spiritual life to require that death be faced without certain modern medical treatments, namely those requiring the reception of blood. Further, they see this rejection of blood as risking harm only to the individual, and to nobody else (although this might be contested from a relational point of view).⁶³

Given the above, and as noted by Justice Binnie,⁶⁴ the interference with A.C.'s religious conscience far exceeded the "non-trivial". However, the freedom of religion claim received scant attention in the two concurring judgments,⁶⁵ the majority contending that allowing evidence of maturity was sufficient to dispose of it. Given the patently 'poor' record of judicial vindication of religious beliefs in the medical context, particularly those of Jehovah's Witnesses,⁶⁶ one would have hoped for a much more thoughtful consideration of the interaction between faith, religious community practices, best interests, minors, and medical treatment. One is left wondering: What is really happening with freedom of religion insofar as its enjoyment by minors is concerned?

We might speculate that the judiciary, which appears to adopt a largely secular, humanist stance, is somewhat suspicious that the (often archaic and dogmatic) religious beliefs which restrain mature minors like A.C. from accepting treatment are often inappropriately considered or only partially understood, or indeed are not personally held with sufficient conviction; these issues are difficult to test in individuals who are not yet fully socially or morally formed, and the best interests approach would seem to necessitate such an assessment, which is jettisoned once the individual reaches maturity.⁶⁷

We might speculate that the judiciary is reluctant to allow minors to make irreversible decisions based on beliefs that some would characterize as superstition and that others would characterize as scriptural misinterpretations; decisions that, upon a reading of the cases, most courts would consider unwise.

Alternatively, judicial resistance to accepting refusals from minors in a highly religious environment may stem from the perception that observance (or subservience) to a scripted religion may circumscribe the minor's horizons, which is to say her ability to seek and consider broader opinions and to think critically, or perhaps rationally.⁶⁸ It is certainly recognized that social context

⁶² The Watchtower Society maintains that transfusions are synonymous with eating blood, which is forbidden in Genesis 9:3-5 and Acts 15:20-29 of the *Old Testament*. For a discussion on Jehovah's Witness policy, see Lee Elder, "Why Some Jehovah's Witnesses Accept Blood and Conscientiously Reject Official Watchtower Society Blood Policy" (2000) 26 *Journal of Medical Ethics* 375-380, and also The Watchman Expositor, "The Watchtower Society's New Policy on Blood Transfusions" (2000), online: The Watchman Expositor <<http://www.watchman.org/jw/jwtransfusions2000.htm>>.

⁶³ For more on Jehovah's Witness policy, see Anonymous, "Are you Resisting the Spirit of the World?", *The Watchtower*, 1 April 1994, 16, and Anonymous, "Questions from Readers", *The Watchtower*, 15 June 2000, 29-31.

⁶⁴ *AC*, *supra* note 3 at para. 215.

⁶⁵ See *ibid.* at paras. 112-13, Abella J; see also paras. 153-56, McLachlin C.J.C.

⁶⁶ See *ibid.* at paras. 57, 59 & 62, Abella J. The characterization of the record as 'poor' is based purely on the fact that most s. 2(a) challenges regarding treatment of minors have not succeeded with the result that, while that life may have been saved (a positive result from many perspectives), that individual's (and his or her parents') s. 2(a) rights have been overridden in a very fundamental way. Ultimately, no court in either the UK or Canada has upheld the refusal of a minor (under 16) of medical treatment that was likely to preserve his or her prospects for a normal and healthy future; concomitantly, courts have upheld a minor's wishes where those wishes are adjudged to be consistent with the minor's best interests, largely determined to be continued life.

⁶⁷ See *Malette*, *supra* note 30 (the Ontario Court of Appeal awarded damages for battery to a Jehovah's Witness who received blood against her express wishes). We might take notice that, regardless of the suspicion with which courts might view religious dogma, they do permit competent adults to refuse treatment.

⁶⁸ See T.H. McLaughlin, "Parental Rights and Religious Upbringing of Children" (1984) 18 *Journal of Philosophy of Education* 75, and Margaret Brazier & Caroline Bridge, "Coercion or Caring: Analysing Adolescent Autonomy" in Michael Freeman, ed., *Children, Medicine and the Law* (Aldershot: Ashgate, 2005) 461; *Re T.D.D.* (1999), 171 D.L.R. (4th) 761 (Sask. Q.B.), [1999] 6 W.W.R. 327, will have done nothing to assuage the perception that religion circumscribes critical-thinking on the part of minors (Experts concluded that TD was less mature than the average thirteen-year-old because his social experiences were limited to his family

has a strong influence on minors and their competency, and social pressures can come from family or peer groups or religious institutions, often invisible or opaque.⁶⁹

The point is that, while the measurable result is that we give rhetorical pre-eminence to autonomy (and some weight to religious freedom), we contract that autonomy when the resultant decision is incomprehensible *and* based on religious tenets, and greater clarity around the interaction of these values and rights, and their exercise by minors (and adults) would have been welcome and useful.

Justice Abella noted that certain scholars advance the position that minors should be permitted to exercise their autonomy only insofar as it does not threaten their life or health.⁷⁰ While seriously denting our notional compliance with autonomy, this would be more intellectually honest insofar as present practices seem to approach the issue of medical treatment of minors on that footing. Similarly, present practices seem to equate best interests with continued life, often with little overt consideration of other relevant factors⁷¹ including ongoing familial relationships and conceptions of “the good death”, which is a significant feature of some cultures.⁷²

Finally, one *might* question the wisdom of “saving” the (religious) child if she is subsequently shunned by family and excluded from other valued social and spiritual contexts, or, more tragically, forced to endure a life in fear that she has lost her immortal soul and place in heaven. We have no evidence concerning A.C.’s post-recovery situation. Despite the transfusion is she accepted by her family and/or her church? Does her faith continue to buoy her? Does she still believe that God is with her or will save her come the end? This is an area where empirical evidence might improve future adjudication. Having said that, the heterogeneity of Jehovah’s Witness communities has been noted, and “pardons” have been extended to both adults and minors who have received blood products.⁷³

CONCLUSIONS: TREATING KIDS LIKE KIDS

Whatever its shortcomings, the consequence of this case is to constitutionally ground the extension to mature minors of the right to make, or, if they are under sixteen, to (only) participate in, decisions with respect to their medical care; its broad stroke is to further entrench the concept of autonomy. However, it permits child welfare authorities to intervene on behalf of a minor (and in contradiction of her wishes) when it considers the minor’s best interests to be better served by an alternate course (i.e., as determined by the court on evidence furnished by the authority and operating within the statutory structure as interpreted by the SCC). Like the Court itself, and as perhaps is apparent, I have a certain

and church, and he was deeply under the influence of his father, who was providing him with inaccurate information about risks and options. The Court concluded that this situation left TD with a lack of understanding or appreciation of the medical treatment he required. Thus, he was considered a minor unable to consent or refuse consent to treatment.); see also *Alberta (Director of Child Welfare) v. H. (B.)* (2002), 329 A.R. 395 (Q.B.), [2002] 7 W.W.R. 616.

⁶⁹ See Jürgen Habermas, “Religion in the Public Sphere” (2006) 14 *European Journal of Philosophy* 1.

⁷⁰ *AC*, *supra* note 3 at para. 79 (Abella J. cites John Eekelaar, “The Emergence of Children’s Rights” (1986) 6 *Oxford J. Legal Stud.* 161); see also *H.(T.) v. Children’s Aid Society of Metropolitan Toronto* (1996), 138 D.L.R. (4th) 144 (Ont. Gen. Div.), [1996] W.D.F.L. 2497 (violating a minor’s freedom of religion is justified where the intent is to save or preserve her life); *Cf. Procureur General du Canada c. Hôpital Notre-Dame et un autre*, [1984] C.S. 426 (Qué. C.S.), 8 C.R.R. 382 (a case concerning a non-minor that held that as a matter of public policy sanctity of life, equated by some with inviolability, could override autonomy).

⁷¹ See *Re Y. (A.)* (1993), 111 Nfld. & P.E.I.R. 91 (Nfld. S.C.), 348 A.P.R. 91 (a Jehovah’s Witness boy was undergoing chemotherapy which was anticipated to have only a 10-40% chance of inhibiting the progress of the cancer), which demonstrates that usually, other factors are only considered in cases where the chances of survival are slim.

⁷² See Karen E. Steinhauser *et al.*, “In Search of a Good Death: Observations of Patients, Families and Providers” (2000) 132 *Annals of Internal Medicine* 825; Tony Walter, “Historical and Cultural Variants on the Good Death” (2003) 327 *British Medical Journal* 218; Kathryn Proulx & Cynthia Jacelon, “Dying with Dignity: The Good Patient Versus the Good Death” (2004) 21 *American Journal of Hospice & Palliative Medicine* 116; Susan Orpett Long, “Cultural Scripts for a Good Death in Japan and the United States: Similarities and Differences” (2004) 58 *Social Science & Medicine* 913.

⁷³ See Kenneth S. Hickey & Laurie Lyckholm, “Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing” (2004) 25 *Theoretical Medicine* 265 at 271.

level of inner conflict—of ambiguity—toward this final disposition.

On the one hand, the protection of autonomy rights is one of the most important means of respecting individuals, and we should not be reticent to vindicate those rights, even when we disagree with them (so long as their exercise does not harm another). Further, the law should reflect social reality, which is complex, even when this injects some uncertainty into the law; the complex reality is that young people are required to navigate through an increasingly complicated and demanding world, and they are expected to process and cope with ever-increasing amounts of information, and, as such, they are increasingly sophisticated and independent-minded.⁷⁴ Therefore, we should be reluctant to force them to bow to the will of adults (or courts) who may, given their own circumstances, know little better than the minor, or who have their own interests rather than the minor's at heart, or who may be vindicating their own values, to which the minor may not subscribe. From this perspective, autonomy generally, and the autonomy rights of minors more specifically (including A.C.'s), have been dealt a regrettable body blow.

On the other hand, in a hard world where life is diminishing in value, it is heartening to believe that we still harbour a respect for life, that we wish to preserve health and possibilities for individual human flourishing, and that we strive to protect vulnerable groups (like children). While young people are developing earlier and face greater challenges than before, and while we absolutely should respect them and treat them well and kindly (and even as equals where circumstances merit it), we should never forget that they are still children, and not fully formed (i.e. most people, upon coming into the fullness of their faculties and having experienced a bit more of life do not hold the same opinions about life and the world that they did when they were fifteen years old; they think differently). While we should vindicate rights, including rights to exercise religion and to refuse unwanted medical treatment, thereby protecting autonomy (and liberty and security of the person), we might properly stop short when the natural result is the death of a young person who could be healed, and who (we believe) has everything ahead of them. In such cases, there is no disgrace in treating them as children; we should exercise judgment intended to help them and keep them alive.

Ultimately, the *CFSA*, as interpreted by the SCC, recognizes the capacity of a minor and permits her to exercise it. Perhaps it represents our best efforts to reconcile autonomy in younger people with our benevolent and paternalistic desire to protect them, and in doing so shows them "sufficient" respect. Perhaps, in the end, we should just "let kids be kids" and not worry that their autonomy rights have been dealt a blow.

⁷⁴ For more on the development of youth and their status in the complex modern world, see Reuven Kahane, *The Origins of Postmodern Youth: Informal Youth Movements in a Comparative Perspective* (Berlin: De Gruyter, 1997), and Frank Biocca, "New Media Technology and Youth: Trends in the Evolution of New Media" (2000) 27 *Journal of Adolescent Health* 22.